Supreme Court, U.S.
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No. _____

IN THE

# Supreme Court of the United States

LITTLE ROCK CARDIOLOGY CLINIC, P.A.; DR. BRUCE E. MURPHY and BRUCE E. MURPHY, M.D.P.A.; DR. SCOTT L. BEAU and SCOTT L. BEAU, M.D.P.A.; DR. DAVID C. BAUMAN and DAVID C. BAUMAN, M.D.P.A.; DR. D. ANDREW HENRY and D. ANDREW HENRY, M.D.P.A.; DR. DAVID M. MEGO and DAVID M. MEGO, M.D.P.A.; DR. PAULO RIBEIRO and PAULO RIBEIRO, M.D.P.A.; DR. WILLIAM A. ROLLEFSON and WILLIAM A. ROLLEFSON, M.D.P.A. *Petitioners,*

v.

BAPTIST HEALTH and BAPTIST MEDICAL SYSTEM HMO, INC. *Respondents.*

**On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit**

## PETITION FOR WRIT OF CERTIORARI

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March 29, 2010

## QUESTIONS PRESENTED

1. Whether as a matter of law patients with private health insurance and patients with Medicare and Medicaid benefits must be in a single antitrust market when government benefits are not interchangeable with private insurance from the perspective of hospitals, doctors, or patients?

2. Whether as a matter of law the relevant geographic market must be at least as large as the defendant's service area when the area of effective competition for the product is a smaller area in which all of the competitors are located?

3. Whether a court may grant a motion to dismiss an antitrust complaint by resolving market allegations and their reasonable inferences against the plaintiffs, when the complaint alleges specific injuries to competition from the alleged acts of monopolization?

## PARTIES TO THE PROCEEDING AND DESIGNATION OF CORPORATE RELATIONSHPS

Petitioner LRCC is an Arkansas professional corporation that is 100% owned by the petitioner cardiologists and their wholly owned individual professional corporations, along with other Arkansas cardiologists and their wholly owned professional corporations, which are not parties to this Petition. LRCC has no parent corporation and no publicly held company owns 10% or more of its stock.

Respondent Baptist Health is an Arkansas non-profit corporation. It has no parent corporation and no publicly held company owns 10% or more of its stock. Baptist Health is the parent company and 100% owner of Respondent Baptist Medical System HMO, Inc.

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Petitioners Little Rock Cardiology Clinic, P.A.; Dr. Bruce E. Murphy and Bruce E. Murphy, M.D.P.A.; Dr. Scott L. Beau and Scott L. Beau, M.D.P.A.; Dr. David C. Bauman and David C. Bauman, M.D.P.A.; Dr. D. Andrew Henry and D. Andrew Henry, M.D.P.A.; Dr. David M. Mego and David M. Mego, M.D.P.A.; Dr. Paulo Ribeiro and Paulo Ribeiro, M.D.P.A.; Dr. William A. Rollefson and William A. Rollefson, M.D.P.A. (collectively "Petitioners") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

## OPINIONS BELOW

The opinion of the Eighth Circuit (Pet. App. 1a) is reported at 591 F.3d 591 (8th Cir. 2009). The opinion of the District Court (Pet. App. 21a) is reported at 573 F. Supp. 2d 1125 (E.D. Ark. 2008).

## STATEMENT OF JURISDICTION

The Eighth Circuit Court of Appeals entered judgment below on December 29, 2009. Petitioners seek review of that judgment by petition for writ of certiorari pursuant to 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

Sherman Antitrust Act, 15 U.S.C. § 1 (Pet. App. 74a).

Sherman Antitrust Act, 15 U.S.C. § 2 (Pet. App. 75a).

Clayton Antitrust Act, 15 U.S.C. § 15 (Pet. App. 76a).

## STATEMENT OF THE CASE

Under Sherman Act sections 1 and 2, 15 U.S.C. §§ 1, 2, 15, Petitioners sued Arkansas Blue Cross & Blue Shield ("Blue Cross"), Baptist Health, and certain of their separate subsidiaries on monopolization and conspiracy claims because Blue Cross expelled Petitioners from the provider network that served all of its managed care insurance customers and Baptist Health terminated Petitioner's privileges at its hospitals, all in retaliation for Petitioners' dealing with a hospital that competed with Baptist Health. Blue Cross and Baptist Health took these anticompetitive acts as part of a reciprocal exclusive dealing arrangement designed to eliminate and prevent the entry or expansion of competitive threats in the market.

The District Court and the Eighth Circuit dismissed Petitioners' complaint for failing to allege an antitrust market as a matter of law. Petitioners have settled with Blue Cross, but their monopoly and conspiracy claims against Baptist Health remain.

### The Market

Blue Cross controlled 90% of the privately insured patients in Arkansas and the cities of Little Rock and North Little Rock in 2006. (Pet. App. 118a-19a) Of the universe of patients in this market, 15% to 20% were uninsured, and the remaining 80% to 85% divided roughly equally into those with private

insurance and those with Medicare and Medicaid benefits. (Pet. App. 88a, ¶ 34) The private, commercial insurance market includes traditional indemnity products, managed-care HMO and PPO products, and employer self-insurance plans. (Pet. App. 86a, ¶ 28; 88a, ¶ 36; 110a-19a)

Baptist Health is the largest hospital company in the state and has two hospitals in Little Rock and North Little Rock. (Pet. App. 81a, ¶ 7; 107a, ¶ 90) It serves 67% of the privately-insured patients in those cities. (Pet. App. 107a, ¶ 91) Baptist Health is the dominant hospital in the Little Rock and North Little Rock, and a commercial health insurance plan cannot effectively operate in that area without having Baptist Health hospitals as providers. (Pet. App. 95a-96a; 99a-104a)

With respect to cardiology services, Baptist Health faces competition from St. Vincent's Infirmary (two hospitals in this market) and Arkansas Heart Hospital. (Pet. App. 105a-09a) The University of Arkansas Medical Center and Arkansas Children's Hospital in Little Rock provide cardiology services to indigent and pediatric patients. (Pet. App. 105a-06a) The five hospital competitors in the market draw more than 90% of the privately insured patients from Little Rock and North Little Rock, and they also draw some patients into Little Rock and North Little Rock from a broad area of central Arkansas. (Pet. App. 19a-92a)

Other than these five hospitals, the nearest hospitals offering cardiology procedures are in Conway (30 miles away), Pine Bluff and Hot Springs

(both 55 miles away). (Pet. App. 90a-93a) These hospitals, however, are not equipped to provide the more specialized cardiology procedures available in Little Rock and North Little Rock and do not have adequate capacity to receive significant numbers of cardiology patients from those cities. (*Id.*) With respect to cardiology procedures, patients do not view these hospitals as reasonable substitutes for the hospitals located in Little Rock and North Little Rock. (Pet. App. 90a, ¶ 42)

The Anticompetitive Conduct

In 1995, Petitioners announced plans to help develop Arkansas Heart Hospital, a specialty cardiology hospital, within a mile of the flagship campus of Baptist Health. (Pet. App. 125a) At that time, Baptist Health and Blue Cross were joint owners of an HMO, HealthAdvantage, that was the largest and most successful in the state. (Pet. App. 124a, ¶ 116) Blue Cross had insurance competitors in the state. (Pet. App. 98a-101a) Petitioners were providers under every plan and policy that Blue Cross offered. (Pet. App. 125a, ¶ 119)

After the announcement, Baptist Health's CEO told one of the Petitioners that specialty hospitals would be "completely cut out of the network" in the future, and the Petitioners might be damaged personally. (Pet. App. 127a-29a) When Arkansas Heart Hospital opened in 1997, Blue Cross terminated the Petitioners from the provider network that served all of its insurance managed-care plans. (Pet. App. 129a-31a) Blue Cross never

admitted Arkansas Heart Hospital as a provider in that network. (Pet. App. 130a-31a)

By 2001, both Blue Cross and Baptist Health had secured monopolies in their markets. (Pet. App. 103a, ¶ 82; 107a, ¶ 91; 119a, ¶ 101) Blue Cross's insurance competitors had left the state. (Pet. App. 102a-03a; 120a) In 2003, in response to the entry into the market of a specialty hospital for neurosurgery, Baptist Health adopted an "economic credentialing policy" under which any physician with an interest in a competing hospital in Arkansas could not maintain privileges to practice at Baptist Health hospitals. (Pet. App. 134a-36a) It adopted this policy after confirming with Blue Cross "no access to the network," according to meeting minutes. (Pet. App. 135a, ¶ 149)

These actions were economically rational because, as the complaint alleges based on public data, Blue Cross paid above-market hospital rates to Baptist Health in return for Baptist Health's agreement to work exclusively with Blue Cross. (Pet. App. 142a, ¶ 175; 150a, ¶ 183) This arrangement made it difficult if not impossible for other insurance networks to compete against Blue Cross because the market rejected health care networks that did not include Baptist Health. (Pet. App. 96a, ¶ 60) The higher hospital rates were passed on to customers in higher health care premiums. (Pet. App. 143a-47a) When Baptist Health asked Blue Cross for protection from the Arkansas Heart Hospital, Blue Cross complied. (Pet. App. 129a-34a)

Blue Cross supported Baptist Health's market dominance because a strong rival to Baptist Health could serve as an anchor to a rival health insurance network. (Pet. App. 120a-23a) To maintain the barriers to entry, Blue Cross was quick to assist Baptist Health by taking actions to either prevent the entry of new hospitals or hobble the economic potential of any hospital that did enter the market. (Pet. App. 123a, ¶ 114; 134a-36a)

As a consequence of this arrangement, consumers paid higher health insurance premiums in part to support the higher hospital fees paid to Baptist Health. (Pet. App. 142a-45a; 150a-51a; 252a-53a) Cardiology patients suffered a decrease in the quality of hospital services. (Pet. App. 140a; 239a-50a) Physicians were forced to choose between falling into step with the Blue Cross/Baptist Health alliance in order to have access to patients covered by private health insurance benefits, or suffering the economic consequence of exclusion from the Blue Cross network. (Pet. App. 125a-38a) Noncompliance meant that physicians would have to base their practices on the lower paying government benefits paid by Medicare and Medicaid. (*Id.*)

Blue Cross took the initial steps against Petitioners. In 2003, Baptist Health took direct action against physicians who owned an interest in a hospital that competed against Baptist Health or were married or related to people who owned an interest in a hospital that competed against Baptist Health. This economic credentialing policy sparked state-court litigation, and its enforcement has been permanently enjoined under state law. *Baptist*

*Health v. Murphy*, 365 Ark. 115, 226 S.W.3d 800 (2006) (affirming preliminary injunction). The permanent injunction is on appeal to the Arkansas Supreme Court.

The Antitrust Litigation

Petitioners alleged that Respondents violated sections 1 and 2 of the Sherman Act by monopolizing and conspiring to restrain trade in the market for privately insured patients who require cardiology procedures in a hospital in Little Rock and North Little Rock. (Pet. App. 88a, ¶¶ 35-36; 154a, ¶ 196; 156a, ¶ 201; 158a, ¶ 209; 160a, ¶ 216a; 161a, ¶ 222) The complaint alleged Blue Cross's market power over these patients in the private insurance market, (Pet. App. 110a-20a), and Baptist Health's market power over them in the hospital market. (Pet. App. 105a-10a)

Specifically, Petitioners alleged that while Baptist Health had 52% of all hospital beds in Little Rock and North Little Rock, it nonetheless garnered 67% of inpatient bed days from non-Medicare and non-Medicaid patients. (Pet. App. 107a, ¶ 91) Baptist Health's market share of the lower-paying government-benefits patients who sought cardiology services was 54%, decreasing to 37% for government-benefits patients seeking cardiovascular surgery. (Pet. App. 108a-09a) Overall, as a result of its relationship with Blue Cross, Baptist Health secured "more of the high-paying insurance market for cardiology patients than it would in a competitive market." (Pet. App. 110a, ¶¶ 93-94)

In the insurance market, Petitioners alleged that in 2001 Blue Cross captured 78% of managed-care health insurance premiums in the State of Arkansas ($846 million in premiums). (Pet. App. 112a-19a) By 2006 this number had risen to 89.48% ($861 million). (*Id.*) Blue Cross's rapid rise was not due to its offering consumers the best health insurance product. In 1997, Blue Cross had less than 50% of this market. The reciprocal exclusive dealing arrangement between Blue Cross and Baptist Health drove seven national insurance competitors out of Little Rock and North Little Rock between 1996 and 2006. (Pet. App. 119a-20a)

The complaint alleged that cardiology patients with private insurance cannot reasonably substitute government benefits for their insurance, and Medicare and Medicaid patients cannot and will not obtain private insurance.

> The government-insurance and private-insurance markets are separate markets because patients cannot substitute one for the other regardless of price differences. Patients obtain Medicare or Medicaid based on age or income; these government benefits cannot be "purchased." Medicare patients could choose to be covered by private insurance rather than Medicare, but this would be irrational in almost all cases because Medicare is for the most part a government benefit to those who qualify.

(Pet. App. 87a, ¶ 32) Further, the complaint alleged that managed-care insurance products require patients to choose providers who are members of the network in order to obtain the full benefit of the insurance. (Pet. App. 87a, ¶¶ 30-31) Medicare and Medicaid patients, by contrast, are able to choose any provider who is willing to serve them. (Pet. App. 86a, ¶ 27)

The District Court dismissed Blue Cross and its entities on the ground that limitations had run. It dismissed Baptist Health and its subsidiary for failure to allege a proper antitrust market. Petitioners settled with Blue Cross while the appeal was pending.

The Eighth Circuit affirmed the dismissal, ruling that (1) Petitioners must allege a "relevant market in order to state a plausible antitrust claim" (Pet. App. 7a), (2) the product market alleged by the plaintiffs was not plausible because it was limited to commercial health insurance and did not include Medicare and Medicaid, and (3) the geographic market alleged by the plaintiffs was not plausible because it did not include the entire area from which Baptist Health drew its patients.

## REASONS FOR GRANTING THE WRIT

Certiorari is warranted in this case because the Eighth Circuit's decision is in conflict with the decisions of other circuits and well established antitrust law on the issue of market definition. If allowed to stand, this decision will impose a significantly heightened pleading standard on

antitrust plaintiffs contrary to this Court's decision in *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007).

The Anticompetitive Effects Conflict

Because the complaint does not allege a *per se* antitrust violation, the Eighth Circuit held that the complaint must allege "a relevant market in order to state a plausible antitrust claim," (Pet. App. 7a) (citation omitted). The Seventh Circuit, however, has held that an antitrust plaintiff may allege an unreasonable restraint of trade under section 1 of the Sherman Act by alleging the anticompetitive effects of the challenged conduct rather than market power in a relevant market. *Toys "R" Us, Inc. v. Fed. Trade Comm'n*, 221 F.3d 928, 937 (7th Cir. 2000). Petitioners' complaint alleges anticompetitive effects of higher insurance prices and decreased quality of care. (Pet. App. 140a-53a)

As the Seventh Circuit noted:

> The Supreme Court has made it clear that there are two ways of proving market power. One is through direct evidence of anticompetitive effects. *See FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 460-61 (1986) ("the finding of actual, sustained adverse effects on competition in those areas where IFD dentists predominated, viewed in light of the reality that markets for dental services tend to be relatively localized, is legally sufficient to support a finding that the challenged restraint was

> unreasonable even in the absence of elaborate market analysis."). The other, more conventional way, is by proving relevant product and geographic markets and by showing that the defendant's share exceeds whatever threshold is important for the practice in the case.

*Id.* (additional citations omitted). The Eighth Circuit's requiring every plaintiff in a case brought under section 1 of the Sherman Act to allege a relevant market conflicts with the decision of the Seventh Circuit in *Toys "R" Us*.

The Market Analysis Problems

On its market analysis, the Eighth Circuit rejected, as too narrow, a market for commercial health insurance because "[p]atients able to pay their medical bill, regardless of the method of payment, are reasonably interchangeable from the cardiologist's perspective . . ." (Pet. App. 10a) The court reached this market conclusion as a matter of law even though the Petitioners alleged numerous industry facts and studies that showed important differences between the private insurance market and the Medicare and Medicaid market. According to the Eighth Circuit, Medicare and Medicaid belong in the same market with commercial health insurance even if substantial differences exist between Medicare/Medicaid and private health insurance in (a) patient characteristics, (b) reimbursement rates, (c) the different costs to providers when dealing with these entities, and (d) a

physician's success and expense in replacing private insurance patients. The Eighth Circuit's combination of private health insurance and Medicare/Medicaid into a single antitrust market, as a matter of law, will make it difficult, if not impossible, for providers to challenge anticompetitive actions by health insurance companies regardless of the level of concentration in the market for private health insurance.

The Eighth Circuit also rejected as a matter of law the geographic market of Little Rock and North Little Rock because Baptist Health drew some patients into Little Rock from different cities. This holding conflicts with the fact-intensive market definition approach taken by this Court and is flatly inconsistent with many cases that have approved hospital markets that were limited to one city or to an area even smaller than a city. *United States v. Rockford Mem. Corp.*, 898 F.2d 1278, 1284-85 (7th Cir. 1990); *Hospital Corp. of Am. v. Fed. Trade Comm'n*, 807 F.2d 1381, 1387-89 (7th Cir. 1986); *United States v. Long Island Jewish Med. Center*, 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997). The Eighth Circuit reached this result by holding that the relevant geographic market cannot be smaller than a hospital's service area regardless of the actual options available to patients in the area. This approach to market definition conflicts with the market delineation process adopted by several other Circuits. The Eighth Circuit's decision imposes impossible pleading obligations on antitrust plaintiffs and will necessarily create artificially large geographic markets that do not correspond to the realities facing patients.

Both of the Eighth Circuit's market determinations erroneously resolved fact-intensive questions on a motion to dismiss, contrary to the allegations of the complaint. The Court found that cardiologists are indifferent to whether they see privately insured patients or Medicare or Medicaid patients, despite the allegation that the reimbursement payments are materially different. The Court found that Little Rock and North Little Rock cardiology patients would turn to hospitals in smaller towns an hour away for their cardiology procedures despite the allegation that those hospitals were not equipped to offer the more sophisticated procedures or to receive a volume of these patients.

## Impact On Health Care

These rulings are even more troubling in view of the segment of the economy at issue. Health care represents by most measures 20% or more of the nation's Gross Domestic Product and presents antitrust market definition issues that are subtle, complex and fact-driven. Seventeen years ago Chief Judge Boudin noted that "the Norman Rockwell era of medicine has given way to a new world of diverse and complex insurance and provider arrangements." *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993).

The complex market arrangements create complex roles for market participants. In one case, Judge Posner observed that "Blue Cross has a dual role in this case, as a buyer of medical services from

Marshfield Clinic and, through its Compcare subsidiary, as a competitor of the Clinic." *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d. 1406, 1415 (7th Cir. 1995). In another he observed, "If you need your hip replaced, you can't decide to have chemotherapy instead because it's available on an outpatient basis at a lower price." *United States v. Rockford Mem. Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990). In *U.S. Healthcare*, Judge Boudin stated, "There is no subject in antitrust law more confusing than market definition. [T]he concept . . . is deliberately an attempt to oversimplify . . . the very complex economic interactions between a number of differently situated buyers and sellers, each of whom in reality has different costs, needs, and substitutes." 986 F.2d at 598 (citing *United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956)).

This case bears out these market realities. Petitioners alleged that Blue Cross was (a) a seller of traditional health insurance plans to employers, (b) through a subsidiary, owner of a provider network that bought medical services from doctors and hospitals for managed care plans, (c) seller of HMO and PPO managed-care plans that used that provider network, (d) partner with Respondent Baptist Health in the company that owned the HMO, and (e) contractor with Baptist Health to acquire Baptist Health's services exclusively for its provider network. Baptist Health was (a) the sole source of hospital services for patients in the Blue Cross provider network, (b) partner in the HMO insurer that used the provider network, (c) seller of hospital

privileges to physicians who treat patients, and (d) competitor to other hospitals.

The complaint contains 75 pages of detailed factual allegations supporting the antitrust claims, including insurance and hospital data from public and regulatory sources that support the relevant market, specifically including market shares and high health-insurance prices. Petitioners included Medicare Provider Analysis and Review ("MEDPAR") data that reveal lower quality care at Baptist Health's hospitals in comparison to the same procedures at Arkansas Heart Hospital. (Pet. App. 239a-50a) These allege actual market-place injuries that occurred because of the absence of competition. Petitioners alleged numerous industry facts and studies that differentiate between the private insurance market and the Medicare and Medicaid market, (Pet. App. 86a-88a; 104a-10a; 127a-28a; 140a, ¶ 166; 153a; 169a-250a), as well as identifying Little Rock and North Little Rock as a relevant health care market. (Pet. App. 89a-93a; 97a-109a; 152a; 169a-237a)

These allegations, accepted as true, established the facial plausibility of the antitrust claims, "factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, ___ U.S. ___, 129 S. Ct. 1937, 1949 (2009). *See also Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007); *Starr v. Sony BMG Music Entertainment*, 592 F.3d 314, 321 (2d Cir. 2010). The alleged markets should have been put to the tests of discovery and proof. Even though the Eighth Circuit found no *Twombly* failing in the

complaint, it erroneously decided the disputed market-definition issues as a matter of law on the motion to dismiss.

## I. THE EIGHTH CIRCUIT'S PRODUCT MARKET RULE CONFLICTS WITH THE DECISIONS OF THIS COURT AND OTHER CIRCUITS.

### A. An Antitrust Complaint That Alleges A Product Market Based On Interchangeability Of Use Or Cross-Elasticity Of Demand Should Not Be Rejected As A Matter Of Law.

At the heart of any delineation of a relevant product market is whether the two different products or services have a sufficient degree of interchangeability or cross-elasticity of demand. "[A]n alleged product market must bear a rational relation to the methodology courts prescribe to define a market for antitrust purposes – analysis of the interchangeability of use or the cross-elasticity of demand, and it must be plausible." *Todd v. Exxon Corp.*, 275 F.3d 191, 200 (2d Cir. 2001) (Sotomayor, J.) (internal quotation and citations omitted). *See United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 380-81 (1956). "Because market definition is a deeply fact-intensive inquiry, courts hesitate to grant motions to dismiss for failure to plead a relevant product market." *Todd v. Exxon Corp.*, 275 F.3d at 199-200 (citing *Found. for Interior Design Educ. Research v. Savannah Coll. of Art & Design*, 244 F.3d 521, 531 (6th Cir. 2001) (in turn citing *Eastman Kodak Co. v. Image Technical Servs., Inc.*,

504 U.S. 451, 482 (1992)) ("Market definition is a highly fact-based analysis that generally requires discovery.").

Petitioner's complaint alleged that patients with private health insurance do not and cannot qualify for Medicare or Medicaid, which qualify recipients based on age, income or similar factors. Patients with Medicare and Medicaid benefits do not have the economic motive or, in many cases, the employment or the money required to purchase private health insurance. (Pet. App. 87a, ¶ 32)

The complaint also alleged the different reimbursement rates to cardiologists from insurers and government programs, so that cardiologists may rationally prefer insured patients over Medicare and Medicaid patients. (Pet. App. 110a, ¶ 94; 153a, ¶ 193) Courts have recognized on properly developed records that price is a compelling factor for holding that products with very similar functions fall into different antitrust product markets. *E.g.*, *United States v. Aluminum Co. of Am.*, 377 U.S. 271, 276 (1964) (holding that copper and aluminum conductors are in distinct product markets and noting that "to ignore price in determining the relevant line of commerce is to ignore the single, most important, practical factor in the business."); *Geneva Pharm. Tech. Corp. v. Barr Labs. Inc.*, 386 F.3d 485, 496-500 (2d Cir. 2004) (holding that generic blood thinner is in different product market from brand-name blood thinner that costs almost twice as much); *U.S. Anchor Mfg., Inc. v. Rule Indus.*, 7 F.3d 986, 995-96 (11th Cir. 1993) (holding that price caused low-price, generic boat anchors to

be in separate product market from more expensive brand-name boat anchors, even though functionally interchangeable).

In determining whether the allegations bear a rational relation to interchangeability or cross-elasticity of demand:

> Industry recognition is well established as a factor that courts consider in defining a market. *See Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962). It is significant because "we assume that the economic actors usually have accurate perceptions of economic realities." *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210, 219 n.4 (D.C. Cir. 1986).

*Todd v. Exxon Corp.*, 275 F.3d at 205. The complaint contains numerous allegations of health-care industry sources that recognize the fundamental differences between private insurance and Medicare and Medicaid benefits in health care markets. (Pet. App. 105a-11a; 140a, ¶ 166)

Whether two products or services have a "sufficient degree" of interchangeability is an economic concept that evaluates whether the seller of one product or service has the ability to restrain the exercise of market power by the seller of the other product or service. Here the issue as framed by the Eighth Circuit is whether physicians can defeat the exercise of market power by Baptist Health and Blue Cross by shifting their practices to Medicare and

Medicaid patients. This is not possible if, as alleged, Medicare and Medicaid patients are not reasonable substitutes for patients covered by private insurance.

The Eighth Circuit erroneously found that physicians are indifferent as a matter of law to whether they receive reimbursement at higher levels from insurance plans or lower levels from government programs. The complaint alleges otherwise, describing the recognized effect of the "payor mix" to health care providers. (Pet. App. 110a, ¶ 94; 153a, ¶ 193) Basic economic theory and antitrust analysis recognize that price differences indicate that products are in separate markets. *Todd v. Exxon Corp.*, 275 F.3d at 203 (allegations that plaintiffs would "suffer large wage losses if they switch industries" was sufficient to differentiate market on motion to dismiss).

The Eighth Circuit has adopted an approach to product market definition that (a) ignores the actual economic and antitrust question addressed by defining a product market, and (b) holds that the complex relationship between patients covered by private health insurance and patients covered by Medicare and Medicaid can be reduced to a rule of law, regardless of the alleged facts. The Eighth Circuit's approach is inconsistent with the approach of the Second Circuit and other courts that require product-market analysis to bear a rational relation to product interchangeability to the purchaser. *Chapman v. New York State Div. for Youth,* 546 F.3d 230, 237-38 (2d Cir. 2008), *cert. denied sub nom., Handle with Care Behavior Management System, Inc. v. N.Y. State Div. for Youth*, 130 S. Ct. 552 (Nov.

9, 2009); *Todd v. Exxon Corp.*, 275 F.3d at 200. A court should not reject a proposed product market as a matter of law when it is based on allegations that relate to the reasonable interchangeability and cross-elasticity of the alleged product with others.

### B. The Eighth Circuit's Rule Limiting Petitioners' Product Market Definition Conflicts With This Court's Precedents In Health Care Cases.

Depending on the injury alleged, the same conduct in an antitrust case can be viewed either as market foreclosure due to exclusive dealing, so that the only ill effects fall on the foreclosed party, or as injury to competition in the defined market, in which case any participant who suffers antitrust injury may recover. *Blue Shield of Va. v. McCready*, 457 U.S. 465, 478-81 (1982); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 29-31 & nn.51, 52 (1984). Petitioners alleged antitrust injury from the Respondents' monopolization and conspiracy in the market, which affected Petitioners' ability to treat (1) privately insured patients in the managed care plans that used the Blue Cross provider network and (2) patients admitted at Baptist Health hospitals.

Thus Petitioners addressed their complaint to the same market that this Court analyzed in *Jefferson Parish*, 466 U.S. at 18 ("[I]n this case our analysis of the tying issue must focus on the hospital's sale of its services to its patients, rather than its contractual arrangements with the providers of anesthesiological services.").

The Eighth Circuit rejected this analysis below and decided as a matter of law that the only inquiry was from the physician's perspective. Though it acknowledged that "[a] court's determination of the limits of a relevant product market requires inquiry into the choices available to consumers" (Pet. App. 7a), and that "from the patient's perspective, private insurance and Medicare/Medicaid are not reasonably interchangeable" (Pet. App. 9a), it rejected these well-pleaded facts and decided that "this lawsuit is not about the options available to patients, it is about the options available to shut-out cardiologists." *Id.* It held: "as a matter of law, in an antitrust claim brought by a seller, a product market cannot be limited to a single method of payment when there are other methods of payment that are acceptable to the seller." (Pet. App. 10a-11a)

By rejecting the possibility that a provider can allege a product market defined from the perspective of the patient, the Eighth Circuit not only rejected the analysis permitted under *Jefferson Parish*, but it severely and erroneously limited the antitrust health-care cases that can be brought by providers.

### C. The Eighth Circuit's Rule Would Impair Antitrust Enforcement In Monopsony And Monopoly Cases.

The Eighth Circuit's rule is inconsistent with antitrust precedents in the field of health care. In *Reazin v. Blue Cross & Blue Shield of Kansas, Inc.*, 899 F.2d 951 (10th Cir. 1990), a national hospital company entered the Wichita, Kansas health care market by acquiring a local health insurer, a local

life insurer, and the dominant hospital, all within a span of six months, posing a competitive threat to Blue Cross of Kansas, the dominant insurer. The Tenth Circuit explained:

> [T]he antitrust issues are relatively straightforward. Plaintiffs' theory was that Blue Cross, alarmed by a perceived competitive threat from Hospital Corporation of America ("HCA") through its acquisitions of a major Wichita hospital now called HCA Health Services of Kansas, Inc. d/b/a Wesley Medical Center ("Wesley"), Health Care Plus, Inc. ("HCP"), and New Century Life Insurance Co. ("New Century"), determined to "hurt" Wesley and thereby send a message to other hospitals not to do business with entities Blue Cross believed were competitors. It did this by agreeing with Wesley's competitors, St. Joseph Hospital and St. Francis Hospital ("the Saints"), to terminate Wesley's contracting provider agreement and to reduce the maximum allowable payments it would make to the Saints, thereby increasing Wesley's costs of doing business and causing a shift of Blue Cross patients from Wesley to the Saints. The threatened termination of Wesley because of its affiliation with a Blue Cross competitor made other hospitals less willing to affiliate with, or enter into relationships with, Blue

> Cross competitors. The result was that Kansas health care consumers were restricted in their access to and benefits from health care financing arrangements involving entities other than Blue Cross, and were deprived of the benefits of competition in that arena.

899 F.2d at 954-55.

As in the case below, Blue Cross of Kansas was the Medicare intermediary for the state of Kansas, but this fact did not cause any of the parties or the Court to question whether patients with Medicare or Medicaid benefits should be in the product market. The parties agreed that the relevant market was "private health care financing," 899 F.2d at 959, and they disputed whether the plaintiff health providers participated in that market. *Id.* at 962-63. The jury found that they did, and the Tenth Circuit affirmed that determination based on the evidence. *Id.* at 964-65.

> We agree with the district court that sufficient evidence supports the jury's finding of an unreasonable restraint of trade in the market for private health care financing. It is not dispositive to us that Wesley was in the health care services market and not itself in the health care financing market. As plaintiffs argue and the district court noted, Wesley was, by virtue of its affiliation with HCA and HCP, a

> perceived competitor of Blue Cross. Indeed, in the Blue Cross Executive Committee meeting August 29, 1985, when the formal decision to terminate Wesley was made, Blue Cross' President Wayne Johnston specifically asked the Committee whether Blue Cross "[wished] to continue to do business with entities that openly desire to compete with the organization and enroll Blue Cross . . . subscribers in their programs." Plaintiffs' Ex. 10, Addendum to Brief of Appellants Vol. I. Further, Wesley was a competitor of Blue Cross' co-conspirators, the Saints.

899 F.2d at 965.

The Eighth Circuit's product market prescription is in direct conflict with *Reazin*. Under the Eighth Circuit's rule, the provider's complaint would have been dismissed for failure to state a claim, with no possibility of discovery or determination of the well-pleaded facts. The decision in *Reazin* directly conflicts with the rule prescribed by the Eighth Circuit below.

The Eighth Circuit's rule is inconsistent with the product markets before this Court in *McCready* and the Seventh Circuit in *Marshfield Clinic*. Each of these health-care antitrust decisions reviewed markets including only those patients who had private insurance. *McCready* affirmed an award to an injured patient with no suggestion that Medicare or Medicaid patients should have been included in

the product market. *Marshfield Clinic* affirmed a liability determination for an insurer in the same circumstances.

Like *Reazin*, the decisions in *McCready* and *Marshfield Clinic* support the alleged product market definition of privately insured patients without Medicare and Medicaid recipients. It was the private insurance market in which Blue Cross and Baptist Health conspired to retaliate against Petitioners by terminating them as network providers. Antitrust courts cannot disregard well-pleaded allegations that patients cannot substitute Medicare or Medicaid for private insurance. The Eighth Circuit's new rule of law combining private insurance and government reimbursement into one market must be struck down.

The Eighth Circuit's ruling would preclude antitrust examination in a broad class of health-care cases by participants such as providers, employers and covered employees. In cases that attack monopolies and conspiracies, the Eighth Circuit's rule would mandate that market power always be determined by reference to the selling opportunities open to the plaintiff. This would "look[] through the wrong end of the telescope," *Todd v. Exxon Corp.*, 275 F.3d at 201 (internal quotation omitted), using a monopsony lens for a monopoly and conspiracy analysis, and would confuse, if not entirely eliminate, rational determination of market power from the consumer viewpoint and based on actual injury to competition. For example, the market in *Reazin* would be deemed to include Medicare and Medicaid selling opportunities for the plaintiff

hospital and doctor, and this would inevitably dilute actionable market power into insignificant market power. Without Medicare and Medicaid in the market in *Reazin*, defendants' market shares ranged from 47% to 62%. 899 F.2d at 969. With Medicare and Medicaid, those shares likely would have been halved on a market measured simply on a per capita basis.

## II. THE EIGHTH CIRCUIT'S GEOGRAPHIC MARKET RULE CONFLICTS WITH DECISIONS OF THE FIRST, SIXTH, ELEVENTH AND DISTRICT OF COLUMBIA CIRCUITS AND REJECTS THE EMPIRICALLY BASED APPROACH TO MARKET DEFINITION REQUIRED BY WELL ESTABLISHED LAW IN FAVOR OF A LEGAL RULE THAT FORESTALLS AN ESSENTIAL FACT-FINDING PROCESS.

Petitioners alleged that the relevant geographic market is the cities of Little Rock and North Little Rock. Petitioners based this geographic market on the facts that the relevant sellers are located there, 99.5% of private cardiology patients in Little Rock and 84.7% of them in North Little Rock use hospitals in that market, these sellers bring patients from a broader area into the market, and hospitals in surrounding towns are neither large enough nor equipped to offer a reasonable substitute to the private patients in the market. (Pet. App. 12a-13a) The allegations were based in part on public data, set forth in the complaint, showing where cardiology patients seek hospital services. The complaint

alleges a long-term study of the Little Rock health care market by The Center For Studying Health System Change, and hearings on competition within this market by the Department of Justice and Federal Trade Commission. (Pet. App. 104a, ¶ 85; 169a-237a)

The Eighth Circuit rejected this market definition as implausible because Baptist Health's service area extends beyond Little Rock and North Little Rock. (Pet. App. 12a) According to the Eighth Circuit, an antitrust plaintiff cannot "limit the relevant geographic market to a location smaller than [the defendant's trade area.]" (Pet. App. 17a)

This conflicts with market-definition cases from this Court. In defining the relevant geographic market, "[t]he proper question to be asked . . . is not where the parties to the merger do business or even where they compete, but where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 357 (1963).

"The determination [of a relevant market] is essentially one of fact, turning on the unique market situation of each case." *H.J., Inc. v. Int'l Tel. & Tel. Corp.*, 867 F.2d 1531, 1537 (8th Cir. 1989) (citations omitted). The notion that market definition is a pragmatic factual exercise is a theme that runs throughout the cases. *See, e.g., Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 467 (1992) ("In determining the existence of market power, . . . this Court has examined closely the economic reality of the market at issue."). Moreover, the geographic

market does not have to be alleged or proven with "scientific precision," *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974), or be defined "by metes and bounds as a surveyor would lay off a plot of ground." *United States v. Pabst Brewing Co.*, 384 U.S. 546, 549 (1966). Instead, the geographic market "must be sufficiently defined so that the Court understands in which part of the county competition is threatened." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998).

The Eighth Circuit's ruling on geographic market definition below converted this factual analysis into a legal one and resolved it with no evidence. This decided an important question of federal law in a way that conflicts with the guiding decisions of this Court.

In place of the required factual analysis, the Eighth Circuit substituted a new legal rule that the geographic market is never smaller than the defendant's trade area. "[W]here, as here, an antitrust plaintiff alleges that a firm competes in and draws its customers from a specific geographic area, it cannot then limit the relevant geographic market to a location smaller than that area based solely on the fact that consumers must travel to that smaller area to obtain the relevant service or product." (Pet. App. 17a)

The decision below is in direct conflict with numerous decisions of other Circuits. In *City of Cleveland v. Cleveland Electric Illuminating Co.*, the Sixth Circuit rejected the "trade area" market definition, stating that "[w]hile there have been

instances where the geographic market has been defined as the defendant's service area, the courts in these cases have emphasized the existence of actual or potential competition throughout the defendant's service area." 734 F.2d 1157, 1167 (6th Cir. 1984). To hold otherwise, the Sixth Circuit reasoned, would yield perverse results in any competition between businesses with differing trade areas. *Id.* (illustrating hypothetical competition between local and regional phone service providers). "This, we believe, is not a result intended by the antitrust laws and certainly not one that we will endorse." *Id.*

The Eighth Circuit's decision renounces mainstream antitrust law represented by the reasoning in *City of Cleveland*. The First, Eleventh, and District of Columbia Circuits have all held that geographic markets are not a function of mechanical rules based on a defendant's trade area; they are based on the economic realities defined by the areas of competition between the parties. *See, e.g.*, *Morales-Villalobos v. Garcia-Llorens*, 316 F.3d 51, 55 (1st Cir. 2003) (on motion to dismiss monopsony claim by excluded anesthesiologist, geographic market may have been as narrow as Arecibo, Puerto Rico, or as broad as the entire United States: "while there are arguments for a larger market, the matter cannot be resolved on the face of the complaint."); *Thompson v. Metropolitan Multi-List, Inc.*, 934 F.2d 1566, 1573-74 (11th Cir. 1991) (rejecting market definition based on defendant's service area because customer could only "practicably turn" to services in a smaller geographic area); *Hecht v. Pro-Football, Inc.*, 570 F.2d 982, 989 (D.C. Cir. 1977) (holding that relevant geographic market is where customers can

"practicably turn" for the parties' competing products, not where plaintiff could have found alternative customers). "The parameters of a given market are questions of fact," not always suitable for summary judgment, much less a Rule 12(b)(6) motion. *See Thompson*, 934 F.2d at 1573-74.

The Eighth Circuit's radical new approach is flatly inconsistent with the guidelines of the Department of Justice and the Federal Trade Commission. The Horizontal Merger Guidelines governing geographic market definition state, "A single firm may operate in a number of different geographic markets." U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines at 15 (as amended April 8, 1997). Petitioners' complaint recognizes this possibility, while the Eighth Circuit's rule eliminates it.

The Eighth Circuit's new rule presents obvious and irrational difficulties of application, such as: when there are two defendants with different trade areas, which one is chosen as the geographic market? The rule would abandon antitrust analysis of geographic markets based on actual market dynamics in favor of judicial fiat that resolves disputed issues without proof and, as here, is outcome determinative.

## CONCLUSION

Judge Boudin, noting the difficulties in antitrust market definition, observed: "rational treatment is assisted by remembering to ask, in defining the market, *why* we are doing so: that is, what is the

antitrust question in this case that market definition aims to answer?" *U.S. Healthcare,* 986 F.2d at 598 (emphasis in original). Rather than ask this guiding question, the Eighth Circuit developed two legal rules in defining product and geographic markets at the pleading stage that bear no rational relation to the injuries and facts alleged in the case. A proper analysis of Petitioners' claimed injuries rationally supports the product market definition in the complaint, and a proper analysis of the market dynamic rationally supports the alleged geographic market.

The complaint alleges markets based on the choices and substitutions available and potentially available to the affected patients, and it describes the antitrust injury to the Petitioners from the Respondents' anticompetitive conduct. These facially plausible allegations should be resolved at trial or on summary judgment, not on a motion to dismiss.

This Court should grant the petition for writ of certiorari to the Eighth Circuit to review the new legal rules and methodologies developed in the erroneous decision below, which contradict settled antitrust law and create grave risks of confusion and disruption in antitrust enforcement in the health care markets.

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